

# EXHIBIT A

# UnitedHealthcare Insurance Company

## UnitedHealthcare Choice Plus

Certificate of Coverage, Riders, Amendments, and Notices

for

NEVADA NANOTECH SYSTEMS, INC.

**Group Number:** GA0X4332NM **Health Plan:** BS - QI **Prescription Code:** 980  
**Effective Date:** January 1, 2020

Offered and Underwritten by  
UnitedHealthcare Insurance Company

# Certificate of Coverage

## UnitedHealthcare Insurance Company

### What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The Certificate describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's Application and payment of the required Policy Charges.

In addition to this *Certificate*, the Policy includes:

- The *Schedule of Benefits*.
- The Group's Application.
- Riders.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

### Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens we will send you a new *Certificate*, Rider or Amendment.

### Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in Nevada. The Policy is subject to the laws of the state of Nevada and ERISA, unless the Group is not a private plan sponsor subject ERISA. To the extent that state law applies, Nevada law governs the Policy.

# Our Responsibilities

## Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the final authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

## Pay for Our Portion of the Cost of Covered Health Care Services

We pay Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Policy.

## Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to us.

## Pay for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

## Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

We may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com](http://www.myuhc.com) for information regarding the vendor that provides the applicable methodology.

## **Offer Health Education Services to You**

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

# Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

## What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

## What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

## How Do You Appeal a Claim Decision?

### Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

### Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

### How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

## Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

"Adverse determination" means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical

necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

## Appeals Determinations

### Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

### Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition. We will provide a decision within 30 days for denials of services already received and for denials of non-urgent care not yet received.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.
- You may obtain an expedited appeals process in urgent cases and contact the Office of Consumer Health Assistance ("OCHA") at:

Office of Consumer Health Assistance  
Governor's Consumer Health Advocate  
555 East Washington Ave., #4800  
Las Vegas, NV 89101  
Phone: (702) 486-3587  
Toll Free: (888) 333-1597  
[http://dhhs.nv.gov/Programs/CHA/\(website\)](http://dhhs.nv.gov/Programs/CHA/(website))  
[cha@govcha.state.nv.us](mailto:cha@govcha.state.nv.us) (email)

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

## Denial of Experimental, Investigational or Unproven Services

If we deny Benefits for a medical procedure or plan of treatment as being Experimental or Investigational Services or Unproven Services and those services are for a Covered Person with a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less), we will provide you with written notification of all of the following:

- Written notice within 5 business days describing how you can request an external review of any decision that denies Experimental or Investigational Services or Unproven Services.
- The specific medical and scientific reasons for the denial and specific references to pertinent Policy provisions upon which the denial is based.
- A description of the alternative medical procedures or treatments covered by the Policy, if any.
- A description of the process of external review explaining how you or your representative can appeal the denial and take part in the review. An external review will be provided to the Covered Person within 30 calendar days following the receipt of a request for external review. An expedited review may be held within 5 business days at the request of the treating Physician.

### Standard External Review

After we receive a notice from OCHA of a request for external review, we will make a preliminary determination of eligibility for the review within 5 business days of the receipt of the request. We will notify OCHA and the Covered Person within one business day after the completion of the review whether the request is eligible for external review. OCHA will assign the external review to an External Review Organization ("ERO"), who will conduct the review.

### Expedited External Review

The treating Physician may submit an oral request if he/she can certify in writing that the treatment would be significantly less effective if not promptly initiated. OCHA will notify us of the request for an expedited external review. We will find out if the request meets the requirements for review and notify OCHA and the Covered Person of that determination. OCHA can overturn our determination that the request is ineligible. OCHA will assign an ERO to conduct the expedited external review.

## Independent External Review Program

If we deny Benefits because it was determined that the treatment is not Medically Necessary or was an Experimental, Investigational or Unproven Service, you may request an Independent External Review from the OCHA at no cost to you. You, your provider, or authorized representative may request an external review if we have not issued a written decision within 30 days on an internal grievance.

You also have the right to request and expedited "internal" grievance and an expedited external review simultaneously when the service or treatment is experimental or investigational and the treating Physician certifies in writing that the service or treatment would be less effective if not promptly initiated.

### Standard External Review

Within 5 business days after receiving the request for external review, OCHA will notify you, other interested parties and us that a request for external review has been filed. OCHA will identify, assign, and provide all documents relating to the adverse determination to the ERO. The ERO will coordinate with you and us for additional information needed to conduct the review. Within 15 days of completing the review, the ERO will submit a copy of its determination to you.

### Expedited External Review

We will approve or deny a request for an external review of a final adverse determination in an expedited manner not later than 72 hours after we receive proof from the Covered Person's provider of health care that failure to proceed in an expedited manner may jeopardize the life or health of the insured.

OCHA will approve or deny a request for an expedited external review within 72 hours after it has determined that the adverse determination concerns:

- An admission, availability of care, continued stay or health care service for which the Covered Person received emergency services but has not been discharged from the facility providing the care; or



- Failure to proceed in an expedited manner may jeopardize the life or health of the Covered Person or the ability of the covered person to regain maximum function.

Upon a determination that the request is eligible for an expedited external review, OCHA will assign an ERO within one working day after approving the request. The ERO will coordinate with us for all documents and information we used to make the adverse determination. Within 48 hours the ERO will notify the Covered Person, his/her physician, and us of its determination by telephone with a follow up in writing.

If the determination of the ERO is in favor of the Covered Person, the determination is final, conclusive, and binding.

**External Review Timeframes:**

- A Physician, Covered Person or authorized representative, may submit a request for an External Review within 4 months after receiving notice of the final adverse determination.
- Within 5 days of receiving the request we will notify the Physician, the Covered Person or authorized representative, the agent who performed the review, and the Office for Consumer Health Assistance that the request was filed.
- The Office for Consumer Health Assistance will assign an External Review Organization and notify us.
- Within 5 days of receiving notification we will provide all documents and materials relating to the final adverse determination including:
  - Medical records;
  - Copy of provision of the health care plan upon which the final adverse determination was based;
  - Documents used by us to make the final adverse determination;
  - Reasons for the final adverse determination; and
  - A list that specifies each provider of health care who has provided health care to the insured and medical record of the provider of health care relating to the external review.
- Within 5 days of receiving the request for external review from the ERO will review the documents and material and notify the consumer, Physician and us if any additional information is required.
- The ERO is to make a determination within 15 days of receiving all information needed for the review.

**When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<p><b>Out-of-Network</b></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.</p>		

## Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. For Covered Health Care Services provided by an out-of-Network provider (other than services otherwise arranged by us), you will be responsible to the out-of-Network provider for any amount billed that is greater than the amount we determine to be an Allowed Amount as described below. For Out-of-Network Benefits, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts. Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

**For Network Benefits,** Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

**For Out-of-Network Benefits,** Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from an out-of-Network provider, Allowed Amounts are determined, based on:
  - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
  - If rates have not been negotiated, then one of the following amounts:

- ◆ Allowed Amounts are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
  - o 50% of *CMS* for the same or similar laboratory service.
  - o 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
- ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
  - o For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com](http://www.myuhc.com) for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - o For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
  - o When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
  - o When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.
- ◆ For Mental Health Care and Substance-Related and Addictive Disorders Services the Allowed Amount will be reduced by 25% for Covered Health Care Services provided by a psychologist and by 35% for Covered Health Care Services provided by a masters level counselor.

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

**IMPORTANT NOTICE:** Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

**For Covered Health Care Services received at a Network facility on a non-Emergency basis from an out-of-Network facility based Physician,** the Allowed Amount is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of *CMS* for the same or similar laboratory service.
- 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com](http://www.myuhc.com) for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

For Mental Health Care and Substance-Related and Addictive Disorders Services the Allowed Amount will be reduced by 25% for Covered Health Care Services provided by a psychologist and by 35% for Covered Health Care Services provided by a masters level counselor.

**IMPORTANT NOTICE:** Out-of-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Allowed Amount described here.

**For Emergency Health Care Services provided by an out-of-Network provider,** the Allowed Amount is a rate agreed upon by the out-of-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.
- The amount that would be paid under Medicare (*part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.*) for the same service.

When a rate is not published by CMS for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com](http://www.myuhc.com) for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

**IMPORTANT NOTICE:** Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.

## Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network

# Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

## Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

## Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

## Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington,

D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.